U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 15 August 2006

Case No. 2004-BLA-6329

In the Matter of

GJ,

Claimant,

v.

TROJAN MINING,

Employer,

and

TRAVELERS INSURANCE CO.,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:[1]

Joseph E. Wolfe, Esq.
Norton, Virginia
For the Claimant

[1] The Director, Office of Workers' Compensation Programs, a party in this proceeding, was not present or represented by counsel at the hearing. By failing to appear at the hearing or participate in this case after referral to this office, the Director is deemed to have waived any issues which it could have raised at any stage prior to the close of this record. By referring this matter for hearing the District Director is further deemed to have completed evidentiary development and adjudication as required by the regulations. 20 C.F.R. § 725.421.

John L. Griffith, Esq.
Paintsville, Kentucky
For the Employer

BEFORE: LARRY S. MERCK
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 ("Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On May 26, 2004, this case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs for a hearing. (DX 31).[2] A formal hearing in this matter was conducted on April 11, 2006 in London, Kentucky, by the undersigned. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. The opinion which follows is based on all relevant evidence of record.

ISSUES[3]

The issues in this case are:

1. Whether the evidence establishes a material change in conditions pursuant to 20 C.F.R. § 725.309(c), (d);

[2] In this Decision and Order, "DX" refers to the Director's exhibits, "EX" refers to the Employer's exhibits, "CX" refers to the Claimant's exhibits, and "TR" refers to the transcript of the hearing.

[3] The Employer withdrew as contested the following issues: (1) timeliness, (2) miner, (3) post-1969 employment, (4) dependency, (5) responsible operator, (6) insurance, and (7) "other issues" listed in #18 of DX 32. (DX 32; TR 14, 15). The parties stipulated to sixteen years of coal mine employment. (TR 15).

2. Whether Claimant has pneumoconiosis as defined in the Act and regulations;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled; and,

5. Whether Claimant's disability is due to pneumoconiosis.

(DX 31; TR 14-15).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background:

Claimant was born on July 17, 1949, and has an eleventh grade education and he is married to F.D. (DX 1, 11).

Claimant's last coal mine employment was with Trojan Mining in 1991. (TR 17; DX 1). Claimant worked as an underground miner for about six months in 1972 and from 1975 to 1991. (DX 11, 3). Claimant's coal mine employment included working as a long wall miner, track and belt operator, scoop and shuttle car operator, hung trolley wire, and laborer. *Id.* In 1991, Claimant ceased coal mine employment because of a general layoff. (DX 11; TR 18). Claimant currently receives Social Security disability benefits and did receive State workers' compensation benefits for eight years. (DX 11).

Claimant filed his first application for benefits on August 5, 1999. (DX 1). The District Director issued a Proposed Decision and Order granting benefits on March 15, 2000. The primary designated operator, Trojan Mining, and Sun Glo, secondary, appealed. The case was referred to the Office of Administrative Law Judges. Administrative Law Judge Robert L. Hillyard denied benefits on October 31, 2001. *Id.*

Claimant filed this second application for benefits on March 20, 2003. (DX 2). The District Director issued a Proposed Decision and Order awarding benefits on February 17, 2004. (DX 21). This matter was transferred to this office after the

Employer submitted a request for a formal hearing conducted by an administrative law judge. (DX 22, 31).

Claimant is treated for his medical problems by the doctors at the Veteran's Administration Hospital in Lexington, Kentucky. (DX 11). He has received medical treatment for his knees, liver, and breathing. He was hospitalized once in the last ten years for sleep apnea. (DX 11). Claimant complains of smothering, shortness of breath, cough with minimal sputum production, wheezing, dyspnea upon exertion, and ankle edema. (DX 7, 9, 11; CX 4; EX 1). He also must use two pillows at night or sleep in a recliner due to his breathing problems. (DX 7). He is prescribed medications for hypertension and his breathing. (DX 11).

The record contains varied statements regarding Claimant's smoking history. At the hearing, Claimant testified that he started smoking as a teenager and smoked for twenty-four or twenty-five years. When he started smoking, he smoked a pack of cigarettes every three days and gradually increased to one and one/half packs of cigarettes a day. He estimated that he averaged smoking a pack of cigarettes a day. (TR 20). At his deposition, he testified that he smoked cigarettes for about twenty years. When he started smoking, he smoked about a pack every two or three days; and when he quit in the early 1980s, he was smoking a pack to a pack and one/half of cigarettes a day. (DX 11). Dr. Rasmussen noted in his first medical report, dated May 19, 2003, that Claimant started smoking at the age of seventeen in 1965 and smoked a pack of cigarettes a day until he quit in 1983. (DX 7). In his second medical report, dated December 11, 2003, Dr. Rasmussen recorded that Claimant started smoking in 1966 and smoked a pack of cigarettes a day until he quit in 1986. (CX 4). In his third medical report, dated September 2, 2004, Dr. Rasmussen noted a smoking history for Claimant that began at the age of seventeen and he smoked a pack of cigarettes a day until he quit in 1984. (DX 4). Dr. Broudy, in his medical report dated May 13, 2003, recorded that Claimant quit smoking about twenty years ago after consuming one to one and one/half packs of cigarettes a day since he was a teenager. (EX 2). Dr. Jarboe, in his medical report dated July 17, 2003, noted that Claimant started smoking when he was eighteen or nineteen and that a pack of cigarettes would last him three or four days. He gradually increased to smoking one to one and one/half packs of cigarettes a day for fifteen or sixteen years, quitting in 1983. (EX 1). The evidence regarding the Claimant's smoking history is contradictory; and therefore, I am unable to make a smoking determination at this time.

Dependency:

It is uncontested that Claimant has one dependent for purposes of benefit augmentation, namely, his wife, S.K. They were married on September 12, 1975 (DX 1). Accordingly, I find that Claimant has one dependent for purposes of benefit augmentation.

Length of Coal Mine Employment:

The parties stipulated to sixteen years of coal mine employment. (TR 15). In Claimant's initial claim, Judge Hillyard found that Claimant had established sixteen years of coal mine employment. (DX 1). Claimant has not had any subsequent coal mine employment; and therefore, the issue of length of coal mine employment cannot be reconsidered in this duplicate claim. *See Sellards v. Director, OWCP*, 17 B.L.R. 1-77 (1993). Claimant last worked in the Nation's coal mines in 1991. (TR 17-18; DX 1, 11).

Applicable Regulations:

Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations. Amendments to the Part 718 regulations became effective on January 19, 2001. As this claim was filed on March 20, 2003, such amendments are applicable.

The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. § 725.414(a)(2)(ii). Likewise, employers and the District Director are subject to identical limitations on affirmative and rebuttal evidence. § 725.414(a)(3)(i, iii).

Subsequent Claim:

Section 725.309(d) provides that a subsequent claim must be denied unless the Claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. The applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. § 725.309(d)(2). If Claimant establishes the existence of one of these conditions, he has demonstrated, as a matter of law, a material change. If he is successful in establishing a material change, then all of the record evidence must be reviewed to determine whether he is entitled to benefits.

Claimant's previous claim was a request for benefits which was ultimately denied by Judge Hillyard on October 31, 2001. (DX 1). The current claim was filed on March 20, 2003, not within one year of the prior denial, so that it cannot be construed as a modification proceeding pursuant to Section 725.310(a). Therefore, according to Section 725.309(d), this claim must be denied on the basis of the prior denial unless there has been a material change in condition.

The previous claim was denied when it was determined that Claimant failed to establish the existence of pneumoconiosis. (DX 1). The Administrative Law Judge did not make findings with respect to total disability or total disability arising out of pneumoconiosis, and as such, Claimant has not met entitlement under these elements. Accordingly, the newly submitted medical evidence will be reviewed in order to determine whether there has been a material change in condition.

Newly Submitted Evidence: Pneumoconiosis:

Pneumoconiosis is defined in Section 718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments, arising out of coal mine employment. This definition includes both medical or "clinical" pneumoconiosis and statutory or "legal" pneumoconiosis.

> (1) *Clinical Pneumoconiosis*. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine

> employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to Section 718.202, the claimant can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under Section 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with Section 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.[4]

[4] At the hearing, there was confusion as to the marking of Claimant's Exhibits. Claimant's Exhibits were received into

Five newly submitted x-rays were offered into evidence. The x-rays dated May 19, 2003, December 11, 2003, and September 2, 2004, were interpreted as positive for pneumoconiosis with a 1/0 profusion by Dr. Manu Patel, a Board-certified Radiologist and a B-reader. (CX 3, 4; DX 7). Dr. Peter Barrett, a Board-certified Radiologist and a B-reader, re-read the x-ray dated May 19, 2003 for quality purposes only. (DX 7, 8). No rebuttal evidence was offered regarding these x-rays; therefore I find these x-rays positive for pneumoconiosis.

Dr. Bruce Broudy, Board-certified in Internal and Pulmonary Medicine and a B-reader, interpreted an x-ray dated May 13, 2003, as negative for pneumoconiosis. (EX 2). Dr. Thomas Jarboe, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, interpreted an x-ray dated July 17, 2003 as negative for pneumoconiosis. (EX 1). No rebuttal evidence was offered; therefore I find these x-rays negative for pneumoconiosis.

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. *Dixon v. North Camp Coal Co.,* 8 BLR 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.*, 7 BLR 1-400 (1984); *Aimone v. Morrison Knudson Co.*, 8 BLR 1-32 (1985) (granting great weight to a B-reader); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 n.5 (1985) (granting even greater weight to a Board-certified radiologist). In this case, a highly-qualified physician interpreted three x-rays as positive.

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evidence as follows: CX 1, Claimant's Amended Black Lung Benefits Act Evidence Summary Form; CX 2, the medical report of Dr. Donald Rasmussen dated September 2, 2004 and his Curriculum Vitae; CX 3, Dr. Patel's September 3, 2004 x-ray interpretation of an x-ray dated September 2, 2004; CX 4, a medical report by Dr. Rasmussen dated December 11, 2000; and CX 5, the progress notes from Cumberland Lung, Asthma and Sleep Specialists, PSC. Within CX 1 there are references to exhibit numbers that are not in accord with the way they were marked at the hearing and received into evidence and those exhibit markings should be disregarded. For clarification purposes, it should be noted that CX 3 is a part of CX 2.

The record also contains more positive interpretations than negative. It is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. *Edmiston v. F & R Coal Co.*, 14 BLR 1-65 (1990). The United States Court of Appeals for the Sixth Circuit has confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is a proper method of weighing x-ray evidence. *Stanton v. Norfolk & Western Railway Co.*, 65 F.3d 55 (6th Cir. 1995) (citing *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993)).

Ultimately, two x-rays were interpreted as negative. (EX 1, 2). However, three x-rays were interpreted as positive. (CX 2, 4; DX 7). Accordingly, I rely on the preponderance of positive readings by a highly-qualified physician in finding that Claimant has established the existence of pneumoconiosis pursuant to Section 718.202(a)(1).

Pursuant to Section 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

The fourth and final way to establish the existence of pneumoconiosis is set forth in Section 718.202(a)(4). This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Field v. Island Creek Coal Co.*, 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.*

On May 19, 2003, Dr. Rasmussen, Board-certified in Internal and Forensic Medicine and a B-reader, examined Claimant for his Department of Labor sponsored pulmonary examination. (DX 7). He considered a coal mine employment history of sixteen and one-half years. Claimant worked as a "laborer, shuttle car operator, ventilation man, track man, belt man, and long wall mine[r]." He noted that the Claimant smoked about one pack of cigarettes a day from 1965 to 1983. Dr. Rasmussen recorded a chronic minimally productive cough, wheezing (increases "with damp weather, or exposure to perfumes, hair sprays, diesel smoke, and dust"), shortness of breath with exertion (fifteen years), ankle swelling, hypertension, and chest pain. Dr. Rasmussen noted that Claimant sleeps in a recliner with two pillows. Claimant was informed, based on results of an electrocardiogram, he had a heart attack in the past and Claimant believes that he had pneumonia as a child. Claimant's medications included Atrovent, Albuterol, Lisinopril, Ranitidine, and aspirin. Dr. Rasmussen provided a full pulmonary workup, including a pulmonary function test, an arterial blood gas study, EKG, and the results of a chest x-ray interpreted by Dr. Patel. The EKG was within normal limits. "Breath sounds were moderately reduced. No rales, rhonchi or wheezes. Heart tones normal." He recorded no edema or clubbing. He considered a chest x-ray interpreted by Dr. Patel as positive for pneumoconiosis with a profusion of 1/0 in all lung zones. An arterial blood gas study, dated May 19, 2003 was not qualifying and a pulmonary function test, dated May 19, 2003, was qualifying pre-bronchodilator but not qualifying post-bronchodilator. Additionally, Claimant underwent a treadmill exercise test that revealed "at least moderate loss of lung function." *Id.*

Dr. Rasmussen diagnosed Claimant with the following: coal workers' pneumoconiosis, based on a positive x-ray and twenty years[5] of coal mine employment; and Chronic Obstructive Pulmonary Disease (COPD) (legal pneumoconiosis) based on Claimant's "chronic productive cough and airflow obstruction." He opined that Claimant's clinical pneumoconiosis was caused by coal dust exposure and that his COPD was due to coal dust exposure and cigarette smoking. He diagnosed Claimant with a moderate pulmonary impairment and determined that he was incapable of performing his last regular coal mine job. He attributed Claimant's pulmonary impairment to three factors: coal mine

[5] The history taken by Dr. Rasmussen reflects sixteen and one/half years of coal mine employment. (DX 7).

dust exposure, cigarette smoking, and probably asthma. He found coal dust exposure to be a significant factor to Claimant's pulmonary impairment. (DX 7).[6]

In all three medical reports, Dr. Rasmussen diagnosed clinical pneumoconiosis based on reported histories of coal mine employment between fifteen and sixteen and one/half years and the positive x-ray interpretations for pneumoconiosis by Dr. Patel. (DX 7; CX 2, 4). In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical judgment under Section 718.202(a)(4). *Id.*, at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 BLR 1-105, 1-110 (1993)(*citing Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113(1989), and *Taylor v. Brown Badgett,* Inc., 8 BLR 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 BLR at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray...and not a reasoned medical opinion." *Id.* As Dr. Rasmussen fails to explain any other reasons for his diagnosis of clinical pneumoconiosis beyond the x-ray and exposure history, I find this portion of his reports neither well-reasoned nor well-documented. (EX 2,4;DX 7).

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[6] On December 11, 2003 and September 2, 2004, Dr. Rasmussen conducted an examination of Claimant which was generally in accord with his clinical observations, findings and conclusions that he recorded in his May 19, 2003 examination. (CX 2, 4). The pulmonary function tests conducted on December 11, 2003 and September 2, 2004 did not qualify pre or post-bronchodilator and the arterial blood gas studies conducted on the same dates were non-qualifying. Also, in the September 2, 2004, examination, Dr. Rasmussen used as a part of his medical report an arterial blood gas study that had not been designated by Claimant as evidence on his Black Lung Benefits Act Evidence Summary Form. (DX 2). Because Claimant had designated only one arterial blood gas study, I will include the September 2, 2004, arterial as his second designated arterial blood gas study.

Therefore, for the reasons discussed, I assign Dr. Rasmussen's opinion less weight as to clinical pneumoconiosis.

Legal pneumoconiosis includes any "chronic lung disease...arising out of coal mine employment." 20 C.F.R. § 718.201. Dr. Rasmussen diagnosed COPD as a result of Claimant's "chronic productive cough and airflow obstruction." He explained the etiology of Claimant's COPD was from "coal mine dust exposure and cigarette smoking." In describing the degree of impairment attributed Claimant's lung disease, Dr. Rasmussen opined that Claimant's disabling lung disease resulted from Claimant's "coal mine dust exposure, his cigarette smoking, and probably asthma" with coal mine dust a significant contributing factor to Claimant's impairment. This conclusion was based on patient history, physical examination, treadmill study, and "significantly reversible obstructive ventilatory impairment" and "minimal resting hypoxia."[7] (DX 7; CX 2, 4). The three arterial blood gas studies relied upon by Dr. Rasmussen were not qualifying. *Id.* Additionally only the May 19, 2003 pulmonary function study was qualifying pre-bronchodilator. All of the later studies were not qualifying. *Id.*

Pneumoconiosis is a fixed condition and any improvement caused by coal dust would not be improved by bronchodilator therapy. Dr. Rasmussen fails to explain why the clearly significantly reversible pulmonary obstruction was significantly related to coal dust exposure and not the other two factors, cigarette smoking and asthma. Accordingly, I assign less weight to this portion of his opinion.

Dr. Broudy, Board-certified in Internal and Pulmonary Medicine and a B-reader, conducted an examination of Claimant on May 13, 2003. (EX 2).[8] The examination consisted of history and physical examination, including a chest x-ray, pulmonary

[7] Dr. Rasmussen, in his medical report, dated September 2, 2004, stated that the pulmonary function study revealed "moderately severe, partially reversible obstructive ventilatory impairment" and "minimal resting hypoxia." (CX 2).

[8] He included copies of medical reports from previous examinations he conducted on Claimant, dated January 14, 2000, January 4, 2000, and November 22, 1991. Employer's designated evidence included two medical reports one from Dr. Broudy dated May 13, 2003 and Dr. Jarboe dated July 17, 2003. As the Employer is limited to two medical reports, I will only consider the two he has designated. (EX 4).

function test, and arterial blood study. Dr. Broudy recorded an employment history that included fourteen and one/half years of underground coal mine employment. Dr. Broudy noted that Claimant started smoking as a teenager and consumed one to one and one/half packs of cigarettes a day, quitting about twenty years ago. He recorded a history of wheezing, dyspnea upon exertion, coughing with occasional sputum production, chest pains that occur without provocation, which last two to three minutes, and swelling in his legs and feet. Additionally, Claimant has trouble sleeping due to his breathing problems and uses an inhaler to help him breath. He takes Lisinopril for hypertension. On occasion, he mows the lawn at home. A chest examination revealed that the lungs have diminished aeration and there is expiratory delay on forced expiration with scattered wheezes. The cardiac examination was normal. His extremities do not have any cyanosis, clubbing, or edema. An x-ray dated May 13, 2003 was interpreted by Dr. Broudy as negative for pneumoconiosis, and the arterial blood gas analysis was non-qualifying. A pulmonary function test showed "evidence of moderately severe obstruction with improvement after bronchodilation." This pulmonary function test, dated May 13, 2003, meets the federal criteria for disability in coal mine employees pre-bronchodilator but not post-bronchodilator. *Id.*

Dr. Broudy's diagnoses included "chronic obstructive airways disease with significant reversible component,. . . obesity, and hypertension." (EX 2). He opined that Claimant did not have coal workers' pneumoconiosis or any COPD caused by coal mine dust. Claimant's COPD was a result of his cigarette smoking and bronchial asthma. In addition, he opined that Claimant is not able to perform his previous coal mine employment or similarly arduous manual labor. *Id*.

Dr. Broudy failed to explain how he eliminated Claimant's years of exposure to coal mine dust in excluding coal mine dust as a possible contributing cause of the Claimant's COPD. *See Cannelton Industries, Inc. v. Director, OWCP [Frye],* Case No. 03-1232 (4th Cir. Apr. 5, 2004) (unpub.) (the court concluded that the ALJ properly accorded less weight to the opinion of Dr. Forehand who found that the miner was totally disabled due to smoking-induced bronchitis but failed to explain "how he eliminated (the miner's) nearly thirty years of exposure to coal mine dust as a possible cause" of the bronchitis. Therefore, I give his opinion less weight. *See Consolidation Coal Co. v. Swiger*, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.).

Thomas M. Jarboe, M.D., Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, examined Claimant on July 17, 2003. (EX 1). He took a patient history of symptoms and recorded an employment history of seventeen years in underground coal mine employment. Dr. Jarboe noted that Claimant starting smoking when he was eighteen or nineteen and a pack of cigarettes would last him three or four days. He gradually increased to smoking one to one/half packs of cigarettes a day. He smoked fifteen or sixteen years quitting in 1983. He recorded a history of shortness of breath (fifteen years), dyspnea on exertion, coronary disease, daily cough, wheezing, and some sputum production (twelve or fifteen years). Dr. Jarboe recorded that Claimant uses an inhaler for his breathing and Lisinopril for hypertension. Claimant has chest pain, high blood pressure, all his joints hurt, and has trouble walking as a result of shortness of breath, and hip and knee pain. Dr. Jarboe noted Claimant's chest examination did not reveal any rales or wheezes but he did have slight diminished breath sounds probably as a result of his weight. Dr. Jarboe interpreted a chest x-ray dated July 17, 2003, as negative for pneumoconiosis. A pulmonary function test dated July 17, 2003, was qualifying pre-bronchodilator but not post-bronchodilator. An arterial blood gas study done on July 17, 2003, was not qualifying. *Id.*

After reviewing the results of the examination and tests, Dr. Jarboe found no evidence of a lung disease caused by coal dust exposure. (EX 1). He stated that the chest x-ray showed no evidence of pneumoconiosis. "The postdilator spirogram indicated a mild restriction and moderate obstructive ventilatory defect." Dr. Jarboe opined that Claimant suffers from the following:

1. Bronchial asthma-based on history of wheezing, aggravated by environmental irritants and reversible airflow obstruction noted on spirometry.

2. Significant obesity-based on physical examination.

3. Essential hypertension-based on physical examination and medical history.

Dr. Jarboe does not relate any of Claimant's conditions to coal dust exposure. (EX 1). Dr. Jarboe states that Claimant's pulmonary function tests showed a reversible component to the

severe airflow obstruction and coal dust exposure does not cause reversible airway disease. *Id.* However, from a respiratory standpoint Claimant is totally disabled. Dr. Jarboe associated the problem with bronchial asthma and cigarette smoking. *Id.*

In addition, the record includes a deposition of Dr. Jarboe taken on July 31, 2003. (EX 3). Dr. Jarboe reiterated the findings in his report and further testified that Claimant does not suffer from pneumoconiosis or any other coal dust related condition. He stated that Claimant suffers from airflow obstruction related to bronchial asthma and smoking. Dr. Jarboe opined that Claimant is totally disabled and unable to perform his regular coal mine employment or comparable work in a dust free environment. *Id.*

In sum, Dr. Jarboe performed a complete pulmonary examination and determined that Claimant did not have legal or clinical pneumoconiosis. He diagnosed Claimant with bronchial asthma due to cigarette smoking. He explained that Claimant has a normal total lung capacity, which indicates that he "has no true restriction or shrinkage of his lungs." (EX 3). Thus, he concluded that Claimant's lung obstruction was not related to coal workers' pneumoconiosis. He also explained why the Claimant's lung disease was not emphysema that was causally related to coal workers' pneumoconiosis. Dr. Jarboe stated "[Claimant] has a pretty severe airflow obstruction but has a normal diffusing capacity...if emphysema were causing the [airflow obstruction] . . . his diffusion would be low." He concludes the basic cause of Claimant's breathing problem is untreated asthma and using an Albuterol inhaler to treat his asthma is poor treatment. *Id.* I find his opinion to be detailed, well-reasoned and well-documented. As such, I assign his opinion full probative weight.

Hospital Treatment Records:

Claimant submitted five pages of progress notes from the Cumberland Lung, Asthma & Sleep Specialists dated August 3, 2004. (CX 5). The notes indicate that he smoked and worked in the coal mines for twenty years. Dr. John C. Rodrigues diagnosed Claimant with pneumoconiosis. However, it is unclear from these notes what information was used to diagnose Claimant with this condition. A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathis Coal Co.*, 6 B.L.R. 1-1182 (1984). Since Dr. Rodriquez failed to provide a basis for his diagnosis, I find

his opinion to be not well-documented or well-reasoned. As such, I assign these notes little probative weight.

Considering all the relevant factors for crediting and discrediting a physician's medical opinion, I find that Dr. Jarboe's opinion outweighs the opinions of Drs. Rasmussen and Broudy. Additionally, I found the Claimant's treatment records insufficient to support a diagnosis of clinical or legal pneumoconiosis. Therefore, Claimant's newly-submitted evidence fails to establish pneumoconiosis under Section 718.202(a)(4).

In sum, I find that Claimant has established that he suffers from pneumoconiosis under Section 718.202(a)(1) but has failed to establish the existence of pneumoconiosis under Sections 718.202(a)(2-4).

Claimant has demonstrated that he has pneumoconiosis, establishing one of the elements of entitlement previously adjudicated against him. Therefore, I must review the entire record to determine Claimant's entitlement to benefits.

Full Review: Pneumoconiosis and Causation

The Claimant's only reviewable previous claim was filed on August 5, 1999. (DX 1).[9] The medical evidence in that claim dates from April 3, 1976 to February 14, 2001. The Board has held that it is proper to afford the results of recent medical testing more weight over earlier testing. *See Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (granting greater weight to a more recent x-ray); *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-17 (1993) (granting greater weight to a more recent pulmonary function study); *Schretroma v. Director, OWCP*, 18 B.L.R. (1993) (granting greater weight to a more recent arterial blood gas analysis); *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985) (granting greater weight to a more recent medical report). As the evidence in the prior claim is years old, I grant greater weight to the newly-submitted evidence.

Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. The previously-submitted evidence contained two positive readings for pneumoconiosis out

[9] The medical evidence which was submitted in Claimant's prior claim was summarized in the October 31, 2001 Decision and Order. (DX 1). Those findings are incorporated herein.

of 36 properly classified x-rays. As the majority of these x-rays were interpreted as negative for pneumoconiosis by physicians who were either B-readers, board-certified radiologists, or both, I find that the previously-submitted evidence was insufficient to establish pneumoconiosis. As stated above, I have found that that the newly-submitted evidence sufficient to support a finding for the disease. I place the greatest weight on Claimant's newly-submitted x-ray evidence because it is the most recent and uncontradicted evidence of record. Therefore, in weighing evidence, I find that the evidence is sufficient to establish pneumoconiosis under Section 718.202(a)(1).

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable herein because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions apply to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides that a claimant may establish the presence of pneumoconiosis through a reasoned medical opinion. The previously-submitted evidence included the reports of Drs. Baker, Broudy, Rosenberg, Branscomb, Chandler, Fino, Repsher, Anderson, and Rasmussen. Out of these pulmonary specialists only Drs. Anderson, Baker, and Rasmussen diagnosed the Claimant with some coal dust related disease. Specifically, Dr. Baker diagnosed the Claimant with an obstructive defect and hypoxemia as a result of coal dust exposure and cigarette smoking. However, he offered no explanation on how he reached that conclusion. Thus, I find the etiologies of Dr. Baker's diagnoses to be based on a generality and, therefore, entitled to less probative weight.

Dr. Anderson diagnosed Claimant with pneumoconiosis based on his positive x-ray reading. The Board permits discrediting of physician opinions amounting to no more than x-ray reading

restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-1405 (1985)). As Dr. Anderson provides no other basis for his diagnosis, I find his opinion to be poorly documented and reasoned.

Dr. Rasmussen diagnosed Claimant with a severe significantly reversible obstructive lung disease. He opined that Claimant's coal mine dust exposure was a significant contributing factor causing his obstruction. Although he attributed the Claimant's lung disease to three risk factors, he failed to explain why he believed the obstruction was due to coal dust exposure, rather than the other two risk factors: cigarette smoking and asthma. I find this lack of explanation makes his report unreasoned. Thus, I assign his opinion less probative weight.

Therefore, in weighing these reports together, I find that the previously-submitted evidence does not support a finding for the disease. As stated above, I have found that newly-submitted evidence was also insufficient to support a finding of the existence of pneumoconiosis. When weighed together, I find that the evidence is insufficient to establish pneumoconiosis under Section 718.202(a)(4).

In sum, I find that Claimant has established pneumoconiosis under Section 718.202(a)(1) but not under Sections 718.202(a)(2-4).

Causation of Pneumoconiosis:

Once pneumoconiosis has been established, the burden is upon Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. §718.203(b) provides:

If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. I have found that Claimant was a coal miner for sixteen years and that he has pneumoconiosis. Claimant is entitled to the presumption that his pneumoconiosis arose out of his employment in the coal mines. No physician opining as to the presence of pneumoconiosis offers an alternative cause to rebut this presumption. *See Smith v.*

Director, OWCP, 12 BLR 1-156 (1989). Therefore, I find that Claimant's pneumoconiosis arose from his coal mine employment.

Newly Submitted Evidence: Total Disability

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b). Total disability can be established pursuant to one of the four standards in Section 718.204(b)(2) or the irrebuttable presumption of Section 718.304, which is incorporated into Section 718.204(b). The presumption is not invoked here because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in Section 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under Section 718.204(c), the precursor to Section 718.204(b)(2), that all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987). Furthermore, Claimant must establish this element by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986).

Subsection (b)(2)(i) of Section 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV_1[10] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[11] or MVV[12] values equal to or less than the applicable table values. Alternatively, a qualifying FEV_1 reading together with an FEV_1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2) and Appendix B.

[10] Forced expiratory volume in one second.

[11] Forced vital capacity.

[12] Maximum voluntary ventilation.

The record consists of five newly submitted pulmonary function studies. [13] (CX 2, 4; DX 7; EX 1, 2). Dr. Rasmussen administered three tests dated May 19, 2003, December 11, 2003, and September 2, 2004, which all contained both pre-bronchodilator and post-bronchodilator tests.(CX 2, 4; DX 7). The test administered on May 19, 2003 by Dr. Rasmussen was qualifying pre-bronchodilator. The other two tests considered by Dr. Rasmussen were not qualifying. The test administered by Dr. Broudy on May 13, 2003 and Dr. Jarboe on July 17, 2003 contained pre-bronchodilator results that were qualifying. Therefore, I must now determine the reliability of the studies based upon their conformity to the applicable quality standards, *Robinette v. Director,* OWCP, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of those particular studies. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). Additionally, all ventilatory studies of record, both pre-bronchodilator and post-bronchodilator, must be weighed. *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981).

The record contains no medical opinion evidence that brings into question or invalidates these studies. Thus, I find that these tests represent Claimant's current respiratory condition. I place the greatest weight on the September 2, 2004 test as it is the most recent test of record and contains both pre and post-bronchodilator values. Therefore, I find that newly submitted evidence does not establish that Claimant is totally disabled under Section 718.204(b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO_2 to pO_2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from Claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations. Five newly offered studies have been entered into the record. (CX 1, 4; EX 1, 2; DX 7). The five newly submitted blood gas studies produced non-qualifying results. *Id.* Therefore, I find that the newly

[13] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find the Claimant's height to be 69-1/2 inches.

submitted blood gas study evidence of record does not establish total disability under subsection (b)(2)(ii).

Total disability under Section 718.204(b)(2)(iii) is inapplicable because Claimant failed to present evidence of cor pulmonale with right-sided congestive heart failure.

Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(2)(iii), Section 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work.

Dr. Rasmussen and Dr. Broudy determined in their medical reports, discussed supra, that Claimant does not have the pulmonary capacity to perform his last coal mining job or similar arduous work. (CX 2, 4; DX 7; EX 2). Dr. Jarboe also concurs that the Claimant does not have the pulmonary capacity to perform coal mine work. However, he believes that the Claimant, with aggressive treatment of his asthma, might result in such improvement in his pulmonary function that he would no longer be disabled. (EX 1). Therefore, I find that the majority of the newly discovered medical evidence supports a finding that Claimant has proven he is totally disabled pursuant to Section 718.204(b)(2)(iv).

Full Review: Total Disability

The previously-submitted evidence consists of six pulmonary function tests in which four were considered to be qualifying. Out of the four tests, three of the tests were invalidated due to the Claimant's effort or cooperation. Therefore, in weighing these reports together, I find that the previously-submitted evidence does not support a finding for total disability. As stated above, I have found that the newly-submitted pulmonary function evidence does not establish that Claimant is totally disabled. Therefore, I find that this evidence does not establish that Claimant is totally disabled under Section 718.204(b)(2)(i).

The record contains five previously-submitted arterial blood gas tests and five newly-submitted tests. None of the arterial blood gas studies are qualifying. As a result, when

weighing this evidence together, Claimant has failed to establish total disability under Section 718.204(b)(2)(ii).

The previously-submitted evidence included the reports of Drs. Baker, Broudy, Rosenberg, Branscomb, Chandler, Fino, Repsher, Anderson, and Rasmussen. Out of these pulmonary specialists, Drs. Rasmussen and Baker were the only two physicians who opined that Claimant was totally disabled. Dr. Baker based his finding of disability on the results of a pulmonary function test he administered to the Claimant. Dr. Burki found the test acceptable but the test was found invalid by Branscomb. (DX 1).

Dr. Rasmussen diagnosed Claimant with a moderate impairment and determined that he was unable to perform his previous coal mine employment. Although he attributed the Claimant's impairment (lung disease) to three risk factors, he failed to explain why he believed the obstruction was due to coal dust exposure, rather than the other two risk factors - cigarette smoking and asthma. Thus, I assign his opinion less probative weight.

Thus, the weight of the previously-submitted evidence is insufficient to establish total disability under Section 718.204(b)(2) (iv).

In sum, I have found the newly-submitted evidence sufficient to support a finding of total disability under Section 718.204(b)(2)(iv). I have also found that the previously-submitted evidence was insufficient to establish total disability under Sections 718.204(b)(2)(i-iv). I assign greater weight to the newly-submitted evidence of record as it represents Claimant's current respiratory condition. Therefore, when weighing the evidence together, I find that the weight of the evidence is sufficient to support a finding of total disability under Section 718.204(b)(2).

Full Review: Total Disability Due to Pneumoconiosis

Section 718.204(c) contains the standard for determining whether a miner's total disability was caused by pneumoconiosis. 20 C.F.R. § 718.204(c) (2003). A miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in Section 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. 20 C.F.R. § 718.204(c)(1) (2003). Pneumoconiosis is a "substantially contributing cause" of the miner's disability if

it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. 20 C.F.R. §§ 718.204(c)(1)(i) and (ii) (2003). Section 718.204(c)(2) states that, except as provided in Sections 718.305 and 718.204(b)(2)(iii), proof that the miner suffered from a totally disabling respiratory or pulmonary impairment as defined by Sections 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by Section 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. 20 C.F.R. § 718.204(c)(2)(2003).

The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith*, 12 F. 3d 504, 506-507 (6th Cir. 1997). The Court has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under Section 718.204) was due "at least in part" to his pneumoconiosis. *Cf.* 20 C.F.R. § 718.203(a). *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's impairment is due to his combined dust exposure, coal workers' pneumoconiosis as well as his cigarette smoking history is sufficient). More recently, in interpreting the amended provision at Section 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP* [*Kirk*], 264 F.3d 602 (6th Cir. 2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id.*

The reasoned medical opinions of those physicians who diagnosed the existence of pneumoconiosis and that the miner was totally disabled are more reliable for assessing the etiology of the miner's total disability. *See, e.g. Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

Of the previously-submitted evidence, Drs. Baker and Rasmussen were the only two physicians who diagnosed the Claimant with pneumoconiosis and opined that he was totally disabled. I find these reports more reliable in addressing the disability causation issue. *Id.* However, I found the previously-submitted evidence insufficient to support a finding under Sections 718.202(a) and 718.204(b)(2). Therefore, I find the previously-submitted evidence is insufficient to establish that Claimant's total disability was due to pneumoconiosis.

Of the newly-submitted evidence, Dr. Rasmussen, in all three of his reports, Dr. Broudy, and Dr. Jarboe all determined that the Claimant was totally disabled. However, Dr. Rasmussen was the only physician who diagnosed the Claimant with pneumoconiosis, both clinical and legal.

When weighed together, I give substantial weight to the newly-submitted evidence as it represents the Claimant's current respiratory condition. For the reasons discussed supra, I give less weight to the opinions of Drs. Rasmussen and Broudy. I rely upon the well-documented and well-reasoned medical report of Dr. Jarboe discussed above. Therefore, I find the weight of the medical evidence is not sufficient to establish that the Claimant's totally disabling respiratory impairment was due to pneumoconiosis under Section 718.204(c).

Entitlement:

In conclusion, Claimant has established that he has pneumoconiosis, that he is totally disabled, but not that his total disability is due to pneumoconiosis. Accordingly, he is not entitled to benefits.

Attorney's Fees:

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any attorney's fees to the Claimant for legal services rendered in pursuit of benefits.

ORDER

It is thereby ORDERED that the claim of GJ for benefits is hereby DENIED.

A

LARRY S. MERCK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).